

Appendix B: Public and provider views on Extended Medicare Safety Net capping arrangements

Public views on EMSN caps

This section provides an overview of the views of members of the public in relation to the capping of Extended Medicare Safety Net (EMSN) benefits. It considers issues, concerns and complaints by members of the public or health care professionals in correspondence received by the Department of Health and Ageing. The Department provided the Centre for Health Economics Research and Evaluation (CHERE) with a sample of de-identified letters. These letters primarily covered concerns in relation to the capping of items for obstetrics and Assisted Reproductive Technology (ART) items. These are considered separately.

Obstetric services

Correspondence in relation to the capping of obstetrics items raised the following concerns:

- increased costs to patients and the overall affordability of obstetrics care following introduction of the caps
- reduced obstetrics choices for women who may delay pregnancy or have no option but use of the public system
- the quality of the public system, and the impact increased demand for public obstetrics care would have on quality
- the timing of the introduction of the caps.

Several correspondents noted the very high out of pocket costs associated with private obstetrics care following the introduction of EMSN caps. Many noted the lower out of pocket costs associated with previous pregnancies compared with the out of pocket costs they had been advised they would face for the current pregnancy, or for future pregnancies. Some correspondents commented that they would need to delay second children. Correspondents commented on the impact that the higher out of pocket costs had on their ability to meet day to day expenses.

A widely expressed concern in the correspondence was the impact that the EMSN caps would have in terms of increased demand for public obstetric services, with detrimental effects on quality of care. Many of these correspondents were unwilling to consider the option of public treatment because of concerns about quality and safety. Others expressed the view that they felt they did not have the option to use the public sector, because of special needs due to high risk pregnancies or other health care conditions. Correspondents argued that high risk pregnancies should be treated differently.

There were commonly expressed views that the measures were unfair on those who had private health insurance. Correspondents expressed concern that following the introduction of the EMSN caps they would face even greater out of pocket costs associated with private obstetrics which are in addition to their private health insurance premiums. Some correspondents stated that these additional costs would make it difficult for them to afford private obstetric services.



Some correspondents questioned the basis for high fees. Opinions expressed in relation to this varied. One correspondent questioned the government's claim that there had been "massively increased fees" following the introduction of the EMSN, and others noted that while fees had increased these increases did not seem unreasonable, or that high fees were an inevitable result of the high insurance costs faced by obstetricians. However, another correspondent expressed the view that the caps should be on fees rather than on benefits, and one correspondent noted that no obstetrician in his/her local area had reduced fees in response to the introduction of caps.

A final set of concerns related to the timing of the introduction of the EMSN caps and the perceived lack of publicity surrounding them. Many correspondents were not aware of the changes until they were booking with an obstetrician, and others noted that they had been introduced with limited publicity. Some noted that although there were associated measures such as the introduction of rebates for midwife deliveries, the timing of these measures meant that they did not provide any benefit for women who were already pregnant and would be affected by the caps.

Assisted Reproductive Technologies services

The correspondence in relation to the impact of the EMSN caps on ART services was largely focused on the impact on affordability of ART, and the impact on the likelihood of a successful pregnancy. Many correspondents provided information about the costs that they faced and noted that they were faced with difficult choices in terms of:

- not being able to manage daily living expenses and continue with their infertility treatment
- delaying their infertility treatment, with concerns about the reduced chances of success
- reducing the number of cycles of treatment, with concerns about the reduced chances of success
- having to change the type of treatment, with concerns about reduced chances of success.

Correspondents described the high emotional burden of infertility with ART treatments, and felt that the additional financial burden as a result of the EMSN caps was particularly difficult. Other correspondents raised concerns about the extent to which the EMSN caps would reduce access to ART.

A number of correspondents noted that infertility was becoming more common, and in many cases resulted from underlying health conditions.

Many correspondents felt that it was unfair that ART had, in their perception, been singled out in the policy change. One correspondent suggested that it would be fairer if there had been reductions in all Medicare rebates rather than caps to specific items. Others noted that it was particularly unfair to infertile men and women that the government had introduced the baby bonus, but made infertility treatment less affordable. Some suggested that measures to address affordability might be introduced, such as interest free loans, or early provision of the baby bonus for those seeking infertility treatments.

Some correspondents raised concerns about the way the caps are applied, questioning the basis for different costs and rebates associated with different types of treatments such as donor cycles and natural cycles. One noted that the way the fees were charged in practice was not consistent with the government's claim that patients charged \$6,000 or less for a typical treatment cycle would not be worse off, because fees had been increased by clinics.



Finally, as with obstetrics, some correspondents felt that it was unfair that the measures had impacted most on out of pocket costs if they had been in response to concerns about fees charged by providers.

Provider views on EMSN caps

As part of this review we consulted representatives from the medical professions. A consultation took place on 2 March 2011 in Sydney with members of the Australian Medical Association (AMA), National Association of Specialist Obstetricians and Gynaecologists (NASOG) and the IVF¹ Directors Group. Following the 2 March meeting, the AMA wrote to the review team to provide a summary of the main issues of interest and concern to the AMA/NASOG/IVF Directors. A further meeting between the review team and representatives from the IVF Directors took place on 28 March 2011.

The AMA/NASOG/IVF Directors discussed the impact of the caps on the EMSN with a particular focus on obstetrics services and ART services.

Impacts on obstetrics services

The AMA noted that an important impact of the EMSN caps has been in terms of a shift in obstetrics services from private hospitals to public hospitals. Representatives argued that the effect of the caps has been to reduce the affordability of private obstetrics services for many women, who will then use public hospital services, and that this impact would be greatest in lower socioeconomic areas. As a result, the increased pressure on some public hospitals will be greater than on others.

The AMA argued that the review should extend to assessment of obstetrics admissions in public and private hospitals, and, in particular consider whether there were variations by geographic region. The AMA/NASOG/IVF Directors provided some commercial in confidence data to the review team that provided support for a reduction in private hospital obstetric admissions and for geographical variation in these impacts. The AMA noted that the review could consider the geographical distribution of private out of hospital services that attracted a Medicare rebate and an EMSN benefit. In line with the AMA's advice, this review closely examined the distribution of EMSN benefits on the basis of geography as well as socio-economic status. The results of this are reported in Section 3.4 of the review.

The representatives of the AMA/NASOG/IVF Directors felt that, in estimating the financial impacts of the EMSN caps, and the impact on the sustainability of the EMSN, that the review should consider the financial cost of additional public hospital obstetrics admissions, as savings on the EMSN may be offset by additional costs to state and territory governments.

The AMA/NASOG/IVF Directors also noted that increased public hospital admissions has other impacts such as more pressure on public hospital nursing staff and increased pressure for early discharge from obstetrics wards, with possible poorer outcomes for mothers and babies in terms of breastfeeding rates.

Subsequent to the 2 March meeting with the AMA/NASOG/IVF Directors, the review team discussed with the Department of Health and Ageing the possibility of obtaining data on the number of public hospital obstetric separations. The Department advised us that due to the normal lags in obtaining data from the states and territories, the Australian Institute of Health and Welfare (AIHW) inpatient data for the full 2010 calendar is, as yet, unavailable. The review team decided that without this data, in particular the latter half of the 2010 calendar

¹ In vitro fertilisation



year, it would not be possible to identify any impact of EMSN caps on public hospital obstetrics separations in the context of this review. Nevertheless this is an important issue and a potential implication of EMSN capping that is worthwhile analysing when more data become available.

Impacts on assisted reproductive technology services

The AMA/NASOG/IVF Directors raised concerns about several possible impacts on women seeking ART and IVF services. In particular, they were concerned that patients may no longer be able to afford the services of clinics that have the highest quality services or deal with more complex cases, resulting in lower IVF success rates. They also noted that a likely impact was that women would delay IVF treatment or have fewer cycles of treatment, resulting in lower success rates. They also raised concerns that women would be more likely to request multiple implants in a cycle, which would increase the risk of multiple births. It was noted that non-singleton pregnancies are both higher risk and more costly to the health system.

At the invitation of the IVF Directors Group, the review team examined data reported by the National Perinatal Statistics Unit (NPSU) at the AIHW. The NPSU reports that in 1993, around 16.1 per cent of cycles resulted in a pregnancy and by the year 2001 this rate had increased to 23.1 per cent (Bryant et al., 2004). Most recent data from 2008 show that the success rate is 22.6 per cent (Wang et al., 2010). The greatest improvement in the success rate occurred in the 1990s, and has been relatively steady over most of the observation period for this report. However, the NPSU has not yet published information on 2009 and 2010 and it is therefore too early to tell whether there were any significant changes in ART success rates after 2008.

The IVF Directors Group drew the review team's attention to the decrease in the multiple birth rate in Australia, as the profession moved to single egg implantation. This has reportedly resulted in Australia having one of the lowest multiple birth rates from IVF in the world. Data from the NPSU shows that in 2004, 40.5 per cent of cycles were single embryo transfers (SET) and this percentage increased to 67.8 per cent by 2008. At the same time, the average age of women using ART services has increased from 35.1 years in 2004 to 35.7 in 2008 (Wang, Chambers, Sullivan, 2010).

In addition, IVF representatives stated the ageing profile of first time IVF patients also contributes to the interpretation of clinical outcomes. Although they also noted that this ageing profile is consistent with the average age of first birth in the general population.

In summary, the number of cycles required for a pregnancy has been stable over recent years but ART is less likely to result in a multiple birth. The reduction in multiple birth pregnancies has further implications on pregnancy risks, outcomes and potential costs.

The IVF representatives noted that around the turn of the century there had been substantial changes in ART and IVF technologies. These changes have resulted in higher costs, and this has contributed to higher fees for IVF and ART services. They noted that the trends in costs in IVF and ART are different from those for other medical services, because of the rapid technological change and innovation.

Whilst representatives noted that the technological improvements have affected both the costs and success rates of IVF, there have been no IVF related assessments by the Medical Services Advisory Committee to list new technologies onto the Medicare Benefits Schedule (MBS) in the last ten years. It was noted that the MBS restructuring that took place in the field of ART, alongside the introduction of EMSN caps, has aimed to improve the alignment between medical practice and Medicare items.

In the meeting with the IVF Directors Group the review team was provided with cost data from two IVF clinics covering the period between 2005 and 2010. This data was provided by the Group to demonstrate that the greatest driver of fee increases in the provision of IVF services over the past five years was not the ability of patients to pay but the cost of provision of services. Representatives from the IVF Directors Group argued that the IVF specialty is different from other medical specialty groups where consulting services form a very high proportion of costs. In IVF a strong multi-disciplinary group of highly specialist professionals including anaesthetists, counsellors, nurses, laboratory technicians and scientists form the majority of professional costs. In addition, Group representatives argued that the capital investment base value per practitioner is much higher to facilitate the comprehensive nature of the IVF process and the laboratory components such as cryogenics, microscopy, molecular biology, pathology and embryology. Furthermore, it was stated that Australian clinics have to compete in an international market for resources including professionals employed in clinics because of the well known shortages of qualified and specialty experienced doctors, nurses and other medical professionals.

The cost data provided by the IVF Directors Group were based on two clinics; clinic A and B. Clinic A was described as initially a small scale facility that underwent considerable upgrading during the period between 2005 and 2010. Clinic B was described as a major facility that was already corporatised at the start of the observation period in 2005. Table B.1 provides details on the average annual growth rates in the number of cycles provided in each clinic as well as some of the major costs components for both clinics observed between 2005 and 2010. It should be noted that not all costs (such as borrowing costs) or returns on investments were made available to the review team. According to the data provided by the IVF Directors Group, Clinic A experienced considerable annual growth in both the number of cycles as well as costs, compared to Clinic B.

Representatives noted that employment costs account for over 50 per cent of total IVF costs. The table shows that these costs have grown considerably over the 2005 and 2010 period, particularly for Clinic A. This growth reportedly reflects an increase in employment numbers and higher wages, which in turn is an indicator of the pressures on the labour force in the field of IVF. Information technology and compliance costs have also increased considerably according to the data provided. Some examples of this are the increasing needs for clinics to maintain records for extended periods and changes in surrogacy laws have resulted in a higher number of counselling sessions and more practitioner meetings. Depreciation costs, reflecting the costs of IVF technologies increased substantially for Clinic A as it was being upgraded and came off a low technology base. Clinic B experienced more modest growth, as it was already on a high cost base. In the case of Clinic B, depreciation costs account for around a 35 per cent of total costs.

Table B.1: Compound annual growth - 2005 to 2010

	CLINIC A	CLINIC B
Cycles	8%	3%
Employment cost	26%	11%
Facility cost	25%	12%
Information technology & compliance costs	37%	15%
Depreciation	127%	3%

Data provided by the IVF Directors Group



Representatives noted that IVF clinics compete on both quality and price, but that there is considerable variation in the level of competition across the country. In most major metropolitan areas there is competition but in some regional areas the level of competition is limited. They reported that the gross cost of an Australian IVF cycle (includes pharmaceuticals provided on the PBS) (based in Euros) is 4,493 compared to 9,960 in the US, 6,766 in Canada, 5,201 in the UK and 4,417 in Scandinavian countries.

Representatives argued that as a result of EMSN caps, cycle numbers and affordability has declined for patients. Particularly for patients in the lower socioeconomic demographic or the resources constrained group trying to meet the needs of higher costs of living (housing and family needs in capital cities) are either being excluded from meeting all their clinically relevant treatment needs or facing less affordable access. These costs plus the funding costs of ongoing credit to secure treatment means the "total financial gap" is increasing.

Representatives stated that economic and social factors are driving up the age at which couples have children. This means that increasing numbers are coming to rely on IVF to address sub-fertility, with one in thirty Australian children (approximately 10,000 annually in Australia) being born through ART. The IVF Directors Group argued that governments, who are reliant on driving longer workforce participation, are either unconcerned or insensitive in cutting the redress of sub-fertile couples to clinical services they need to meet their social and family aspirations.

The AMA/NASOG/IVF Directors also noted that it would be valuable for the review to consider the overall impact of the EMSN caps on out of pocket costs for women who undergo both IVF or ART treatment and have a successful pregnancy and require obstetrics care. Whilst the review does not explicitly examine women who undergo both ART services and private obstetrics in this review, it does include analysis of episodes of care in both the ART and obstetrics setting.

Other issues

The AMA/NASOG/IVF Directors noted that the growth in benefits paid by private health insurance funds has been higher than the benefits paid through Medicare. They suggested that private health insurance benefits may more accurately reflect market prices for medical services than MBS fees. They also noted that changes in fees for some services, such as treatments for varicose veins, may be confounded by the outcomes of Medical Services Advisory Committee assessments and other policy changes that have occurred over the same time period.

References

Bryant, J., Sullivan, E., Dean, J., (2004). Assisted reproductive technology in Australia and New Zealand 2002. AIHW cat. No. Per 26, Australian Institute of Health and Welfare National Perinatal Statistics Unit, Sydney.

Wang, Y. A., Chambers, G. M., Sullivan, E. A., (2010). Assisted reproductive technology in Australia and New Zealand 2008. Assisted reproduction technology series no.14. Cat. No. Per49, AIHW, Canberra.